

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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August 9, 2010

Victoria Wachino, Director
Family and Children's Health Programs Group
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Dear Ms. Wachino,

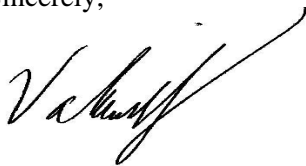
Thank you for taking the time to meet with TTAG on July 28th, 2010. We appreciate the information you brought to the discussion and look forward to working closely with you in the coming years.

Please find attached an updated packet of some of the Affordable Care Act provisions that concern us. We anticipate that the Outcome Measures as well as the action steps will be updated on an ongoing basis. The Act presents great opportunities and challenges for Indian Country. Only by working closely together can we assure that this law will bring improvements in access to health care for American Indians and Alaska Natives.

We will be forwarding additional information to you as it is developed. Because of the complexity of the law and the broad role Tribes play as governments, employers, purchasers and providers, we value your assistance in engaging TTAG in a cooperative discussion.

Please don't hesitate to contact me if you would like additional information.

Sincerely,



Valerie Davidson, Chair

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TTAG Recommended Patient Protection and Affordable Care Act Outcome Measures

August 5, 2010

1. Significantly increase the rate of health coverage for *all* American Indians and Alaska Natives.

Measure: American Indians and Alaska Natives will have the same health coverage rates as the general population.

Note: Measuring this outcome will require data that is currently unavailable. In order to move forward to collect and analyze this data, HHS and CMS must engage TTAG in detailed discussion that includes implementation of PPACA Section 4302.

Measure: HHS regulations will remove barriers to and facilitate the enrollment of eligible American Indians/Alaska Natives, both on and off reservations, in Exchange plans, high risk pools, Medicare and Medicaid.

(1) HHS regulations will establish a mechanism for I/T/Us to group pay applicable premiums on behalf of their beneficiaries in order to facilitate enrollment.

(2) The regulations will assure that qualified health plans (a) exempt Indians at/below 300% of the Federal Poverty Level from all premiums and cost-sharing associated with enrollment in an Exchange plan, as intended by PPACA Sec. 1402(d), and (b) define the term "Indian" in broad terms that indicate the kinds of documentation that could support the individual as qualified for the exemption, using as a model CMS regulations implementing the Indian exemption from Medicaid premiums and cost-sharing, and identifying the types of documentation that would suffice as appropriate documentation. *See* 75 FED. REG. 30247-48, 30261 (May 28, 2010).

(3) The regulations will require Exchanges to display eligibility information sufficient to fully inform individual Indians of all exemptions to which they are entitled in order for such individuals to make informed decisions with regard to enrollment.

(4) CMS will monitor and report back to TTAG about State Medicaid Expansions and identify how barriers to American Indian/Alaska Natives enrollment have been removed, whether the Indian health programs will continue to be able to provide services to AI/AN, and if adequate Tribal consultation occurred.

2. Financially strengthen Indian health providers so programs can expand service capacity and access to health care.

Measure: American Indians and Alaska Natives will have access to high quality Indian health providers across the country and will no longer experience denial of care due to Contract Health Service rationing or participation in Affordable Care Act programs.

Measure: Regulations will facilitate full participation by I/T/Us in PPACA programs, including designating I/T/Us as "essential community providers" required to be admitted to Exchange plan networks, and modifying network contract terms to accommodate the unique circumstances of the Federally-created I/T/U system.

Measure: Exchange regulations will require health plans to pay I/T/Us the reasonable charges billed, or, if higher, the highest amount the health plan would pay other non-governmental provider, as required to Sec. 206 of the Indian Health Care Improvement Act.

3. Significantly reduce the glaring health disparities that oppress American Indians and Alaska Natives.

Measure: American Indians and Alaska Natives will have the same or better health status as the general population. Evaluation should monitor progress toward meeting the Health People 2010 objectives; or proposed Healthy People 2020 objectives.

Measure: In implementing PPACA Sec. 4302 (Data Collection), the Agency for Healthcare Research and Quality should (i) consult with Indian health data experts and tribal epidemiology centers; and (ii) establish data fields specific to AI/ANs served by federally-supported health programs in order to capture the following information:

- Demographic characteristics and health status
- Number of AI/ANs enrolled in each federally-supported program
- Disaggregation of all data fields by I/T/U program
- Such other data as recommended by Indian health data experts and tribal epidemiology centers.

4. Ensure that Tribal leaders and Indian health program staff receive training to understand how PPACA works and are supplied with adequate resources to educate and enroll community members in new or expanded health programs.

Measure: Tribal governments and tribal enterprises as employers will receive information about their specific roles and responsibilities as well as benefits and opportunities of PPACA implementation.

Measure: Outreach and education about Medicare changes will specifically target AI/AN elders through I/T/Us as well as Area Agencies on Aging.

Measure: HHS will offer accessible training courses in all IHS regions by 2012 on subjects that include: new rules for Medicaid eligibility and enrollment, and

calculation of MAGI; internal workings of the Exchanges and mechanics for acquiring coverage and qualifying for subsidies; and other PPACA topics.

5. **Ensure that all Indian communities directly benefit from new funding opportunities, grants and initiatives in a way that compliments the cultural context of their existing health programs.**

6. **Implement Indian specific provisions as effectively and efficiently as possible.**

Measure: The Secretary will establish an administratively simple and easy to use method for certifying Indians as exempt from the individual mandate penalty.

(1) The term "Indian" will be defined in broad terms that indicate the kinds of documentation that could support certification of the individual as qualified for the exemption, using as a model CMS regulations implementing the Indian exemption from Medicaid premiums and cost-sharing, and identifying the types of documentation that would suffice as appropriate documentation. *See* 75 FED. REG. 30247-48, 30261 (May 28, 2010).

(2) The Secretary's regulations will provide that certification as Indian for purposes of exemption from the individual mandate penalty shall be valid for such individual's lifetime and that periodic re-certifications will not be required.

Measure: By January 1, 2011, implement the amendment to the Medicare Part D program (Sec. 1860D-2 of the Social Security Act) to count the value of drugs dispensed by an I/T/U pharmacy toward the true out-of-pocket ("TrOOP") costs of an Indian enrolled in such plan.

(1) All CMS Medicare Part D solicitation and instruction materials for 2011 will require Part D plan sponsors to have in place no later than January 1, 2011, mechanisms to implement this TrOOP amendment. (2) Within a reasonable time, Medicare Part D regulations will be revised to reflect the TrOOP amendment.

Measure: CMS will assure that, effective January 1, 2011, in coordination with TTAG, the version of the Indian Health Addendum used for all Medicare Part D network provider agreements with I/T/Us reflects all changes in applicable laws, including the "TrOOP fix" and amendments made to the Indian Health Care Improvement Act by Sec. 10221 of the PPACA.

Measure: HHS will report back to TTAG (?) on steps taken and outcomes of implementation of Indian Specific

7. **Recognize that the Indian health system is very different from the mainstream health delivery system and, therefore, assure that it is protected from any adverse consequences not intended by the statute, and that it receives express mention in regulations in order to achieve this outcome.**

8. **Require all Department of Health and Human Services agencies that have implementation responsibilities to engage in meaningful Tribal Consultation that respects the federal trust responsibility and Government-to-Government relationship with Tribes.**

Measure: Carry out the United States' trust responsibility for Indian health by evaluating the impact of all provision of the PPACA on the unique Indian health delivery system and include in regulations language specific to that system, as needed, to assure that Indian health providers (I/T/Us) can utilize program opportunities and are protected from unintended adverse consequences.

Measure: HHS agencies will pursue Tribal Consultation through regional meetings, conference calls and solicitation of technical assistance from tribal policy experts throughout the regulations development process.

Measure: CMS will adopt and implement a Tribal consultation policy.

Measure: All federal entities responsible for implementing PPACA will demonstrate consistency, transparency and accountability to Tribes and collaborate with them throughout the process.

**ASSURING THE INCLUSION OF
INDIAN HEALTH PROVIDERS
IN PROVIDER NETWORKS OF EXCHANGE PLANS**

In general. Beginning in 2014, the states (or the Secretary of HHS) are required to have in place Exchanges where health insurance products will be made available to eligible individuals and small employers. The PPACA requires the Secretary, by regulation, to issue criteria for certification of qualified health plans that will be permitted to list products on the Exchanges. Sec. 1311(c)(1) requires a qualified health plan to ensure a sufficient choice of providers and include in its provider network "essential community providers" that serve predominately low-income, medically-underserved individuals.

The revised Sec. 206 of the Indian Health Care Improvement Act (IHCIA) provides an Indian health system providers with the right to recover from a third-party payer, including an insurance plan, "the reasonable charges billed", or, if higher, the highest amount the plan would pay for care provided by other providers.¹ This payment requirement applies to providers that are (i) Indian Health Service-operated programs; (ii) health programs operated by Indian tribes or tribal organizations through Indian Self-Determination and Education Assistance Act agreements; and (iii) urban Indian organizations assisted by grants issued pursuant to Title V of the IHCIA – collectively called "I/T/Us".

Indian Country Objectives. To fully implement the statutory command regarding inclusion of essential community providers, and to assure that Indians enrolled in Exchange plans can fully utilize the coverage provided, the regulations for the Exchanges must assure that I/T/Us are admitted to provider networks and receive reimbursements at rates required by Sec. 206 of the IHCIA. Specifically, the regulations must achieve the following objectives:

1. Include I/T/Us in the definition of "essential community provider".
2. Require qualified health plans to include special provisions in their network provider agreements with I/T/Us that take into account the unique circumstances of I/T/Us under Federal law and regulations. Such provisions are needed to overcome barriers that could otherwise impede participation by ITUs in provider networks.
3. Require qualified health plans to comply with Section 206 of the IHCIA with regard to reimbursement. Section 206 grants to an I/T/U the right to recover its

¹ The revisions to Sec. 206 of the IHCIA are included in S. 1790 which was enacted into law by Sec. 10221 of the Patient Protection and Affordable Care Act.

reasonable charges billed or, if higher, at the highest rates paid to any provider, regardless of whether I/T/Us are in provider networks.

Justification for Objectives

1. I/T/Us meet the description of "essential community providers".

Sec. 1311 requires qualified health plans to offer a sufficient choice of providers, and to include essential community providers in their networks in order that insured individuals can fully utilize their insurance coverage. Essential community providers are those that serve predominately low-income, medically-underserved individuals. The law gives the following examples of essential community providers, but does not restrict the term to those examples.

- *Providers described in PHSA Sec. 340B(a)(4) [42 USC 256b(a)(4)]* – Entities eligible to obtain discounted drugs from the 340B program. These include: FQHCs; family planning projects under PHSA 1001(a); HIV outpatient grantees; AIDS drug purchasing assistance programs; black lung clinics; hemophilia treatment centers; Native Hawaiian Health Centers; urban Indian organizations; HIV health care centers; STD and tuberculosis programs; certain hospitals serving low-income individuals.
- *Providers described in Sec. 1927(c)(1)(D)(i)(IV) of the Social Security Act* – tax-exempt entities; entities that serve the same types of populations as the providers described in PHSA Sec. 340B(a)(4); and public, non-profit, or college health centers that offer family planning services.

As 340B-eligible providers, urban Indian organizations are clearly among the entities Congress had in mind for "essential community providers". Tribally-operated outpatient clinics are also eligible for FQHC status² and many have acquired this designation. Furthermore, the circumstances of IHS and tribal programs put them squarely in the category of essential community providers.³ They are often the only source of health care in remote, sparsely-populated Indian communities, and due to the high rate of poverty in Indian communities, their service population includes a significant number of low-income individuals. The well-documented, shocking health disparities suffered by Native Americans⁴ makes this population sicker, on average, than other components of the American public, and inadequate

² Secs. 1861(aa)(4) and 1905(1)(2)(B) of the Social Security Act.

³ Doubtless IHS and tribally-operated health programs would also have been expressly included in the list of entities eligible for discounted drugs under the Sec. 340B program if they did not already have another source through which to obtain pharmaceuticals at a discount – the Federal Supply Schedule prime vendor program administered by the Department of Veterans Affairs.

⁴ See, e.g., United States Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, Sept. 2004.

appropriations to the IHS makes the Indian population "medically-underserved" by any definition.

The poorer-than-average health status of Indian people presents a major disincentive for health plans to seek out the I/T/Us who serve this population to join their provider networks. Unless the regulations require inclusion of I/T/Us in provider networks, Indian enrollees will not have sufficient access to providers, and qualified health plans will realize a windfall by collecting premiums for Indian enrollees without the requirement to pay network provider rates for the services they receive.

Congress recently recognized the imperative for leveling the playing field for I/T/U providers when it required States to include in their Medicaid managed care contracts a requirement to admit I/T/Us to provider networks. It also requires managed care entities to agree to pay an I/T/U provider – regardless of whether it is or is not in a provider network – at the same rate the entity would pay a network provider that is not an I/T/U.⁵

2. Special requirements for provider network agreements.

The unique nature and circumstances of I/T/Us, and the statutory and regulatory restrictions, to which they are subject, make it necessary to require modification to or deletion of standard health plan network contract provisions for these providers. In fact, the Secretary, in carrying out the United States' trust responsibility for Indian health⁶, has an *affirmative obligation* to take such actions to facilitate full participation by the Federally-created Indian health delivery system in all Federally-supported health programs.

There is precedent for requiring special terms for agreements between health plans and I/T/Us. When implementing the Medicare Part D prescription drug benefit, CMS required prescription drug plans to utilize a special Indian Health Addendum for agreements with I/T/U pharmacies.⁷

At a minimum, the facilitating regulations must include the following topics:

- *Persons eligible for services.* Federal law and regulations limit the persons eligible for services at I/T/Us. These include Sec. 813 of the Indian Health Care Improvement Act

⁵ Sec. 1932(h) of the Social Security Act [42 USC §1396u-2(h)], enacted by Sec. 5006(d) of the American Recovery and Reinvestment Act.

⁶ See Secs. 2 and 3 of the Indian Health Care Improvement Act, 25 USC §§1601, 1602, including revisions thereto made by S. 1790 enacted into law by Sec. 10221 of the PPACA.

⁷ 42 CFR §423.120(a)(6). The text of the current CMS-approved Indian Health Addendum appears in the Medicare Prescription Drug Benefit, Solicitation for Applications for New Cost Plan Sponsors, 2011 Contract Year, at pp. 133-139. As a result of provisions enacted in the PPACA, including revision to the IHCA, this Medicare Part D Indian Health Addendum must now be up-dated.

- (IHCA) [25 USC §1680c]; 42 CFR Part 136; and the terms of the contract, compact or grant issued by the Secretary of HHS to an Indian tribe, tribal organization or urban Indian organization. Network provider contract must permit I/T/Us to limit services to those individuals who may be served under Federal law and regulations.
- *Applicability of other Federal laws.* The regulations must require recitation in provider contracts of Federal laws and regulations applicable to I/T/Us, including the following:
 - The Anti-Deficiency Act, 31 USC §1341 (applicable to the IHS)
 - The Indian Self-Determination and Education Assistance Act, 25 USC §450 *et seq.*, and regulations at 25 CFR Part 900, Subpart M
 - The Federal Tort Claims Act, 28 USC §2671-2680
 - The Federal Medical Care Recovery Act, 42 USC §2651-2653 (applicable to the IHS); and the equivalent application provided to Indian tribe, tribal organization and urban Indian organization providers by Sec. 206(e)(3) of the IHCA [25 USC §1621e(e)(3)]
 - The Federal Privacy Act of 1974, 5 USC §552a, and 42 CFR Part 2
 - Confidentiality of alcohol and Drug Abuse Patient records, 42 CFR Part 2
 - The Health Insurance Portability and Accountability Act, and regulations at 45 CFR Parts 160 and 164
 - The Indian Health Care Improvement Act, 25 USC §1601 *et seq.*
 - *Recognition of non-taxable entity status.* I/T/U providers, as non-taxable entities, must not be required to collect or remit any Federal, State or local tax.
 - *Special insurance and indemnification provisions.*
 - IHS, Indian tribe and tribal organization providers and their employees are covered by the Federal Tort Claims Act. Thus they must not be required by a network contract to obtain or maintain private professional liability insurance, or to otherwise indemnify a qualified health plan.
 - To the extent that an urban Indian organization is covered by the FTCA pursuant to PHSA Sec. 224(g)-(n) and regulations at 42 CFR Part 6, such entity must not be required by a qualified health plan to obtain or maintain professional liability insurance, or to otherwise indemnify a qualified health plan.
 - *Employee licensing; eligibility for payment.*
 - Under Federal law, employees of the IHS and tribally-operated health programs are not required to hold a license in the state in which the program operates as long as they are licensed in another state.⁸ Thus, a qualified health plan cannot

⁸ The new Sec. 221 of the IHCA, as enacted into law by Sec. 10221 of the PPACA, exempts a health professional employed by a tribally-operated health program from the licensing requirements of the state in which the program is operated if such professional is licensed in any state.

- require licensing in the state as a condition of network provider status nor as a condition for payment for services.
- Similarly, to the extent that an IHS or tribal facility is not subject to state licensing requirements, holding such a license cannot be a condition for eligibility for payments.
- *Disputes resolution; governing law.*
 - Federal law must govern the resolution of disputes with the IHS.
 - No provider agreement should subject any Indian tribe, tribal organization or urban Indian organization to state law to any greater extent than state law is already applicable.
- *Medical Quality Assurance Programs.* Any medical quality assurance programs required by any qualified health plan must be subject to the new Sec. 805 of the IHICA.
- *Reimbursement Rate.* Provider agreements with I/T/Us must comply with Sec. 206 of the IHCA which provides an I/T/U the right to receive from all third-party payors the reasonable charges billed, or, if higher, the highest amount the third party would pay for care provided by any other provider.
- *Prohibition on assessment of cost-sharing on Indian enrollees.* Provider agreements must assure that an I/T/U provider is not required to collect cost-sharing from an Indian patient. This is needed to comply with Sec. 1402(d)(2) of the PPACA which prohibit assessment of cost-sharing on any Indian enrolled in a qualified health plan for a service provided by an I/T/U or through referral under a contract health services program.
- *Days, hours of operation.* Qualified health plans must not be permitted to impose any minimum requirements regarding the days or hours of operation of an I/T/U program as a condition for participation, as such requirements can act as a barrier to participation.
- *Sovereign Immunity.* Nothing in a provider agreement constitutes a waiver of Federal or tribal sovereign immunity.

3. Qualified Health Plan Payment Requirements for I/T/Us – IHCA Sec. 206 Directive.

The Secretary's regulations must require qualified health plans to comply with Section 206 with regard to reimbursement to I/T/U providers. Section 206 gives the I/T/U provider the right to recover the reasonable charges billed or, if higher, at the highest rates paid to any provider. See Sec. 206(a) and (i), as set out in S. 1790, enacted into law by Sec. 10221 of PPACA. This requirement must apply *regardless of whether an I/T/U is a network provider.*

It is vital that this payment directive expressly appear in the Department's Exchange regulations so that qualified health plans know about and obey it from the beginning. Since this is a Federal law, it is HHS's responsibility to enforce it. If it is not included in the regulations, violations are very likely to occur, particularly if an I/T/U is not in a particular health plan's network. This would put the Department in the position of having to bring enforcement actions against non-compliant health plans, and to file claims for underpayment on behalf of the Indian Health Service, tribes, tribal organizations and urban Indian organizations. The more efficient and effective mechanism is to make this a regulatory requirement.

Tribes/Others Paying Premiums and Cost Sharing

In general. A key aspect of PPACA is providing “affordable” health coverage for all Americans. For people who are not eligible for Medicare, Medicaid, employer sponsored or other health coverage, they must purchase insurance on their own through the “individual group” market. By 2014, health insurance plans must meet certain regulations, including offering basic benefits with various cost sharing structures in order to be offered through an insurance Exchange. An Exchange can be accessed through a web-based tool where an individual without health insurance can compare plans and purchase the one that best suits their needs. People with incomes below 400% FPL (\$43,320 for a single person and \$88,200 for a family of 4 in 2009), will qualify for a premium subsidy. The lower income brackets will pay the least for premiums. Until 2014, States (or HHS in the place of a non-participating State) will set up High Risk Pools where individual health insurance is available for people with pre-existing conditions. The premiums are subsidized with federal funding so the rates are similar to commercial plans, but there is no low-income subsidy. *The Exchanges, where individual health plans can be purchased, become effective in 2014. High risk pools will be available no later than January, 2011 and will end in early 2014.*

Indian aspects. Special exchange rules for people who are American Indian and Alaska Natives (AI/AN) will make it much more accessible for participation. The exemption from cost sharing and monthly enrollment periods will help AI/AN both on and off reservations achieve portability of coverage. The most significant obstacle to accessing this benefit is the premium. (We believe there will be no premium for Indian people below 300% FPL). Although individual AI/AN may want to purchase insurance through the Exchange on their own, many will not because they are exempt from the mandate and already are entitled to receive health care through the Indian health system. There are many benefits for Tribes and Indian health programs to consider paying premiums on behalf of beneficiaries. These include increased health program revenues, decreased CHS expenditures, reduced reliance on CHEF funding and guaranteed benefits. Sec 9021 of PPACA clarifies that AI/AN cannot be taxed if a Tribe, IHS or Tribal organization purchase their coverage and Sec 152 of IHCA permits Tribes to purchase insurance for IHS beneficiaries. Unfortunately, there is no clear mechanism that will allow a Tribe to directly pay a high risk pool or Exchange plan premium on behalf of an eligible member.

Indian impact. If HHS can facilitate an option for direct payment of premiums by Tribes and Indian health programs, AI/AN have the potential of achieving significantly higher health insurance rates.

Details. The Office of Consumer Information and Insurance Oversight (OCIIO) is responsible for all aspects of insurance reform including developing federal policies and regulations related to how the Exchanges and High Risk pool operate. Jay Angoff is the Director and reports to the HHS Secretary. States will also have a variety of options for how they will run the Exchange and High Risk Pools in their State or Region.

To do items:

1. TTAG, Tribes and Indian health programs should develop a relationship with OCIIO. They are one of the most influential offices in HHS for PPACA implementation.
2. Educate OCIIO on why Tribal, IHS or Urban Indian organization premium payment is important to improve AI/AN access to health coverage. Identify options for simple, cost effective ways for Tribes and Indian health programs to directly pay premiums.
3. Because premium payment is such a significant barrier to Indian enrollment in Exchange plans or high risk pools, the regulations should establish an administratively simple mechanism which allows Tribes and Indian health programs to group-pay premiums on behalf of individual beneficiaries. Such group payment mechanisms are now used for enrolling individual beneficiaries in Medicare Part D plans. Since Exchanges will likely be operated by the states, the HHS regulations must expressly require the availability of such group pay options in order to assure the state systems will include them.
4. Request project funding to develop premium payment programs.

Use of High Risk Pools

In general. Section 1101 creates temporary “high risk pools” where individuals without health coverage with pre-existing conditions can purchase health insurance. States are permitted to run their own pools or, if they elect not to do this, HHS will provide the coverage. Premiums are to be set at the same rate as the standard population. Although there is \$5 Billion available to States to subsidize the premiums so they are comparable to other commercial plans, there is no low income subsidy available. Individuals with creditable coverage are not eligible for the high risk pools – they must be uninsured for at least 6 months. *Although PPACA makes this provision effective June 30, 2010, some high risk pools may not be available until January, 2011. These temporary high risk pools are scheduled to end in early 2014 when enrollees will be switched to plans offered through the Exchanges.*

Indian aspects. There are no Indian specific provisions. It is possible that for some AI/AN, paying the high risk pool premiums would be preferable to paying for the health care services they need, for example if a person has certain types of cancer. It might also be advantageous for a Tribe to pay high risk pool premiums on behalf of a member who is eligible and does not qualify for any other type of coverage.

Indian impact. AI/AN enrollment in high risk pools has the opportunity to save individual AI/AN and Indian health programs that pay for their health care from catastrophic costs. Families USA reports that an estimated 25% of non-Medicare, non-institutionalized AI/AN have a pre existing condition that would prevent them from being able to purchase individual health insurance on their own. Although the number of AI/AN likely to enroll in high risk pools may be small, the savings could be significant for individual cases.

Details. The Office of Consumer Information and Insurance Oversight (OCIIO) is responsible for implementation of the High Risk Pools. Jay Angoff is the Director and reports to the HHS Secretary. States will also have a variety of options for how they will run the high risk pools in their State or region. OCIIO currently has posted the solicitation of bids from States.

To do items:

5. Develop a relationship with OCIO. They are the most influential office in HHS for PPACA implementation. Each State will also have a variety of policies that will impact access for AI/AN enrollment in high risk pools.
6. Educate OCIO on why direct Tribal premium payment is important to improve AI/AN access to health coverage. Find options for simple, cost effective ways for Tribes and Indian health programs to directly pay premiums.
7. Clarify with OCIO that IHS is not creditable coverage, nor is it considered “minimum acceptable coverage” in PPACA.
8. Work with OCIC to identify a simple mechanism for Indian health programs to provide documentation of pre-existing conditions for AI/AN beneficiaries who wish to enroll in a high risk pool.
9. Work with OCIO to draft regulations and/or convey information to States about AI/AN eligibility for high risk pools, mechanisms for documenting pre-existing conditions and Tribal or Indian health program payment of premiums.

Modified Adjusted Gross Income - Treatment of Indian Income

In General; Definition of MAGI. The new law will rely on a Federal income tax calculation called Modified Adjusted Gross Income (“MAGI”) in determining eligibility for certain tax credits and for Medicaid and CHIP. MAGI is calculated by adding back certain income otherwise excluded from adjusted gross income, which IRS defines as gross income minus adjustments to income. For the purposes of determining eligibility for the benefits under PPACA, the income that is added back is that excluded for citizens and residents of the U.S. who are living abroad (section 911 of the Internal Revenue Code) and interest earnings on tax exempt bonds.

Indian Aspects. There are no provisions in the Internal Revenue Code that exempt an individual from payment of Federal income tax solely on the ground that the person is an Indian. However, there are certain forms of income received by Indians that are exempt from Federal income tax. See, summary of exemptions below. The income that must be added back to determine MAGI does not include any of the income Indians are specially allowed to exclude from the determination of adjusted gross income.

Federal Tax Exemptions for Indians. The principal exemptions enjoyed by Indians from adjusted gross income are summarized below.

1. **Judgment Funds Distributions.** Per capita shares distributed to Tribal Members pursuant to the Indian Tribal Judgment Funds Use or Distribution Act, 25 U.S.C. § 1401, et seq., including interest and investment income earned on Judgment Funds while under administration, are not subject to federal or state income taxes. 25 U.S.C. § 1407.
2. **Tribal Trust Income Per Capita.** Per capita shares distributed to Tribal Members by the Bureau of Indian Affairs or a Tribe, 25 U.S.C. §117a, from tribal trust income collections, e.g., lease rentals, rights-of-way payments, oil or mineral royalties, or timber harvesting, are not subject to federal or state income taxes. 25 U.S.C. §§ 117b(a) and 1407.

3. Income Directly Derived from a Trust Allotment. Based upon its construction of the General Allotment Act, 24 Stat. 388, the United States Supreme Court held that income directly derived by an individual Indian from his or her trust allotment was not subject to federal income tax. *Squire v. Capoeman*, 351 U.S. 1 (1956). That principle has been extended to income directly derived from allotments governed by other Congressional Acts. *Stevens v. Commissioner*, 452 F.2d 741 (9th Cir. 1971). The IRS construes “directly derived” to mean rents, royalties, proceeds from natural resource or crop sales, grazing permit income, and sale of livestock raised on the land. Rev. Rul. 67-284, 1967-2 C.B. 55. Courts have held that the exemption with respect to allotments does not extend to business income derived from business operations on allotted land, such as income from restaurants, motels, apartments, smoke shops, and craft shops. *Critzer v. United States*, 597 F.2d 708 (Ct.Cl. 1979); *Saunooke v. United States*, 806 F.2d 1053 (Fed. Cir. 1986); *Hoptowit v. Commissioner*, 78 T.C. 237, 145 (1982), *aff’d* 709 F.2d 564 (9th Cir. 1983); *Dillon v. United States*, 792 F.2d 849 (9th Cir. 1986); *Beck v. Commissioner*, 1994 WL 100623, T.C. Memo 1994-122 (Tax Ct. 1994), *aff’d*, 64 F.3d 655 (unpublished), 1995 WL 508884 (4th Cir. 1995). That income has been held to be produced by business and economic factors largely separate from the land itself.

4. Fishing Rights. Income of a Tribal Member derived from “fishing rights related activity” in the exercise of “recognized fishing rights” is not subject to federal income tax. 26 U.S.C. § 7873.

Pursuant to 25 U.S.C. § 1407, the income discussed above in paragraphs 1 and 2 is also excluded from benefits eligibility from computations for any program under the Social Security Act, including Medicaid. In some instances, although not with regard to programs under the Social Security Act, the amount of the exclusion may be limited to \$2,000. Experience with at least some states regarding their exclusions suggest that the exclusions described in paragraphs 3 and 4 have been incorporated by those states as exclusions from various means tested programs.

Details. Under the Patient Protection and Affordable Care Act (“PPACA”), as amended by the Health Care Reconciliation Act of 2010 (“Reconciliation Act”), modified adjusted gross income (“MAGI”) is a factor in determining eligibility for various benefits made available under the PPACA. See e.g., PPACA Section 1401 (adding a new section 36B to the IRC (relating to refundable tax credit providing premium assistance for coverage under a qualified health plan) and Sec. 2002 (Amending Sec. 1902(e) of the Social Security Act regarding Medicaid income determinations).

The PPACA, as enacted, used the phrase “modified gross income.” Section 1004(a) and (b) of the Reconciliation Act amended the PPACA tax, Medicaid, and CHIP provisions to substitute “MAGI” for “modified gross income” and amended the tax provisions (Sections 36B(d)(2) and 5000A(c)(4) of the Internal Revenue Code) to define MAGI to mean “adjusted gross income increased by (i) any amount excluded from gross income under section 911 [relating to exclusions from gross income for citizens and residents of the U.S. who are living abroad], and (ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.” Both the Medicaid and CHIP provisions that rely on MAGI define it as it is defined in Section 36B(d)(2) of the Internal Revenue Code.)

To Do Items. This paper was limited to an explanation of how MAGI is calculated and whether it has any negative tax implications for Indians. It does not appear that it does. We know that two of the Federal tax exemptions accepted by the Internal Revenue Service are also applicable to programs under the Social Security Act, which would include Medicaid. The others are also made available at least by some states.

Whether there are additional exemptions that States provide that are not addressed in the Internal Revenue Code is not clear. The only way to determine this would be to catalog the current State exemptions and compare them with the exemptions listed above.

- See if the CMS can identify the income exemptions allowed by State and compare them to the exemptions that will continue to be permitted for Indians under the MAGI calculations.

* * * * NOTICE * * * *

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Medicaid Expansion

In general. By 2014 Medicaid will be expanded to include all Americans with incomes below 133% FPL. Asset and resource limits will also be eliminated. Eligibility will be based on “modified adjusted gross income” (MAGI). States have incentives to expand coverage prior to 2014, but are not required to do so. Key to this change is that adults without children will be able to enroll in Medicaid. There are also a number of enrollment simplifications including direct on-line enrollment. The temporary HHS web portal and Exchanges will provide information about eligibility and benefits. CHIP is authorized only through 2015. A Federal Coordinated Health Care Office (CHCO) has been established within CMS to “align” Medicare and Medicaid policies, benefits and financing for dual eligible’s – people enrolled in both Medicare and Medicaid. PPACA also included an appropriation to establish the Medicaid and CHIP Payment and Access Commission (MACPAC) and expands the scope of the group. *Full implementation by 2014.*

Indian aspects. There are no specific provisions for ITUs or AI/AN. Because ITU are heavily dependent on Medicaid reimbursement, changes in Medicaid policies can be opportunities or threats.

Indian impact. Although these changes are federal requirements, States will still have significant leeway in how they operate their Medicaid and CHIP programs. Overall the Medicaid expansion will add a large number of new eligible’s and will make enrollment and renewal much easier. There is no new funding for the outreach, education and enrollment activities that need to take place. Furthermore, ITUs in each State will have to work closely with their Medicaid programs to make sure policies and implementation actually improve access. Section 5006 of ARRA requires States to seek the advice of Tribes and Indian health programs prior to making changes that are likely to have a direct effect on Indian health programs. To a large extent, it will be up to ITU programs to help their State implement this requirement.

To do items:

1. TTAG should identify implementation responsibilities assigned to CMS and ensure there is an ongoing, effective strategy to proactively advise CMS.
2. TTAG should work with CMS to clarify and advise on issues related to Indian income and MAGI.
3. TTAG should work with CMS to advocate for the inclusion of Indian specific eligibility information to be included on websites as well as with Section 2201- Enrollment Simplification and Coordination with State Health Insurance Exchanges.
4. TTAG should again request that a Tribal representative be appointed to the MACPAC and other key advisory groups, and that resources be provided to enable meaningful participation.
5. TTAG should learn more about CHCO and ask CMS to identify the best way to advise on policies related to AI/AN dual eligible's.
6. IHS should be encouraged to work within HHS to ensure adequate ITU access to grants and contracts for education, outreach and enrollment.

Medicare Part D "TrOOP" fix.

In General. Under the regulations to implement the Medicare Part D law, CMS refused to treat the value of prescription drugs dispensed by IHS, tribal or urban Indian (I/T/U) pharmacies to Indian patients enrolled in a Medicare Part D drug program as "true out-of-pocket" costs. This meant that when such an Indian patient reached the "donut hole" (the period when Part D provides no coverage), he/she would not be able to eventually qualify for the catastrophic coverage phase of Part D where 95% of drug costs are covered because I/T/U-dispensed drugs were not considered true out-of-pocket costs of the patient. The new law corrects this problem. It provides that the value of drugs dispensed by I/T/U pharmacies shall be considered "true out-of-pocket" costs. *This provision becomes effective Jan. 1, 2011.* [Sec. 3314]

Indian impacts. When the Medicare Part D "TrOOP" fix becomes effective Jan. 1, 2011, drugs dispensed by I/T/U pharmacies will count as true out-of-pocket costs and thus Indian patients heavily reliant on prescription drugs could eventually reach the catastrophic coverage level in a year. When that occurs, I/T/U programs will be able to collect from Part D plans at the catastrophic coverage level.

NOTE: The new law will phase out the "donut hole" over the next 10 years and it will be eliminated by 2020. For 2010, a \$250 rebate will be paid to Medicare patients who reach the "donut hole".

To do:

Get the word out. Part D plans should already have mechanisms in place to designate when a dispensed drug is to be added to a patient's TrOOP total. Thus, the most important To Do action is to assure that Indian patients served by I/T/Us get added to those mechanisms effective Jan. 1, 2011. This means that news of this change in the law must be timely delivered to –

- I/T/U pharmacies – this action should be performed by IHS as soon as possible so that pharmacies can communicate with the Part D plans in which their patients are enrolled.
- Part D plans – this action should be performed by CMS. If new regulations will not be in place by Jan. 1, 2011, CMS should send a special bulletin to all approved Medicare Part D plans and include mention of this new provision in all future applications for Part D plan approval.

Indian Addendum. TTAG and IHS should also revise the Indian Addendum to Part D plan agreements in time for it to be approved by CMS and distributed prior to the 2010 enrollment window